A-Engrossed
House Bill 2046

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires insurer to provide specified notice to insured or prospective insured enrolled in short term health insurance policy.

Prohibits insurer from establishing due date for payment of first individual health benefit plan premium earlier than 15 days after coverage begins or after date invoice is sent, whichever is later.

Authorizes Department of Consumer and Business Services to access, use and disclose data in all payer all claims database for carrying out department's duties, subject to conditions.

Requires grace period of at least 30 days for payment of premium for individual health benefit plan.

Requires notice of adverse benefit determination to be provided in culturally and linguistically appropriate manner and specifies elements that must be included in notice.

Adds new provisions applicable to external review by independent review organization.

Requires insurer to send notice of nonpayment of premium at least 15 days prior to end of grace period established for individual health benefit plans.

Removes or modifies certain references to federal law in laws concerning health insurance.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; and amending ORS 442.373, 743.417, 743B.005, 743B.250, 743B.252, 743B.254, 743B.255, 743B.323 and 743B.422.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this 2021 Act are added to and made a part of the Insurance Code.

SECTION 2. (1) An insurer offering a short term health insurance policy in this state shall include in any policy document, application materials or advertisements related to the policy a notice informing an insured or prospective insured under the policy that:

(a) The policy is not subject to certain federal requirements for health insurance, including requirements in the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152);

(b) The insured or prospective insured should carefully review the policy documents; and

(c) If the policy expires or an insured loses coverage under the policy, the insured may have to wait until the next annual open enrollment period to enroll in another policy of health insurance.

(2) The Department of Consumer and Business Services may adopt rules to implement this section, including rules prescribing the form or manner of the notice described in subsection (1) of this section or any additional information that must be included in the notice.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

SECTION 3. An insurer offering an individual health benefit plan may establish a due date for payment of the first premium for the plan no earlier than 15 days after the date that the coverage begins or 15 days after the insurer sends the initial invoice to the insured, whichever is later.

SECTION 4. ORS 442.373 is amended to read:

442.373. (1) The Oregon Health Authority shall establish and maintain a program that requires reporting entities to report health care data for the following purposes:

(a) Determining the maximum capacity and distribution of existing resources allocated to health care.

(b) Identifying the demands for health care.

(c) Allowing health care policymakers to make informed choices.

(d) Evaluating the effectiveness of intervention programs in improving health outcomes.

(e) Comparing the costs and effectiveness of various treatment settings and approaches.

(f) Providing information to consumers and purchasers of health care.

(g) Improving the quality and affordability of health care and health care coverage.

(h) Assisting the authority in furthering the health policies expressed by the Legislative Assembly in ORS 442.310.

(i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity.

(2) The authority shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that:

(a) Establish the time, place, form and manner of reporting data under this section, including but not limited to:

(A) Requiring the use of unique patient and provider identifiers;

(B) Specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to Oregon residents in other states; and

(C) Establishing enrollment thresholds below which reporting will not be required.

(b) Establish the types of data to be reported under this section, including but not limited to:

(A) Health care claims and enrollment data used by reporting entities and paid health care claims data;

(B) Reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the authority to be necessary to carry out the purposes of this section; and

(C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards.

(3) Any third party administrator that is not required to obtain a license under ORS 744.702 and that is legally responsible for payment of a claim for a health care item or service provided to an Oregon resident may report to the authority the health care data described in subsection (2) of this section.

(4) The authority shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.

(5)(a) The authority shall use data collected under this section to provide information to con-

sumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

(b) The authority shall, using only data collected under this section from reporting entities described in ORS 442.372 (1) to (3), post to its website health care price information including the median prices paid by the reporting entities to hospitals and hospital outpatient clinics for, at a minimum, the 50 most common inpatient procedures and the 100 most common outpatient procedures.

(c) The health care price information posted to the website must be:

(A) Displayed in a consumer friendly format;

(B) Easily accessible by consumers; and

(C) Updated at least annually to reflect the most recent data available.

(d) The authority shall apply for and receive donations, gifts and grants from any public or private source to pay the cost of posting health care price information to its website in accordance with this subsection. Moneys received shall be deposited to the Oregon Health Authority Fund.

(e) The obligation of the authority to post health care price information to its website as required by this subsection is limited to the extent of any moneys specifically appropriated for that purpose or available from donations, gifts and grants from private or public sources.

(6) The authority may contract with a third party to collect and process the health care data reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the data for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all data collected and processed under the contract to the authority.

(7) The authority shall facilitate a collaboration between the Department of Human Services, the authority, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the data reported under this section and collected by the authority under ORS 442.370 and 442.400 to 442.463. The authority, in consultation with interested stakeholders, shall:

(a) Formulate the data sets that will be included in the system;

(b) Establish the criteria and procedures for the development of limited use data sets;

(c) Establish the criteria and procedures to ensure that limited use data sets are accessible and compliant with federal and state privacy laws; and

(d) Establish a time frame for the creation of the comprehensive health care information system.

(8) Information disclosed through the comprehensive health care information system described in subsection (7) of this section:

(a) Shall be available, when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal laws, as a resource to insurers, employers, providers, purchasers of health care and state agencies to allow for continuous review of health care utilization, expenditures and performance in this state;

(b) Shall be available to Oregon programs for quality in health care for use in improving health care in Oregon, subject to rules prescribed by the authority conforming to state and federal privacy laws or limiting access to limited use data sets;

(c) Shall be presented to allow for comparisons of geographic, demographic and economic factors and institutional size; and

(d) May not disclose trade secrets of reporting entities.

(9) The collection, storage and release of health care data and other information under this section is subject to the requirements of the federal Health Insurance Portability and Accountability Act.

(10)(a) Notwithstanding subsection (9) of this section, in addition to the comprehensive health care information system described in subsection (7) of this section, the Department of Consumer and Business Services shall be allowed to access, use and disclose data collected under this section by certifying in writing that the data will be used only to carry out the department's duties.

(b) Personally identifiable information disclosed to the department under paragraph (a) of this subsection, including a consumer's name, address, telephone number or electronic mail address, is confidential and not subject to further disclosure under ORS 192.311 to 192.478.

SECTION 5. ORS 743.417 is amended to read:

743.417. (1) [*An individual health insurance policy*] **A policy of health insurance issued to an individual residing in this state** shall specify a minimum grace period [*of at least 10 days after*] **following** the premium due date for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. **Unless a longer grace period is provided by federal law, the grace period must be at least:**

(a) Ten days for a policy other than an individual health benefit plan; and

(b) Thirty days for an individual health benefit plan.

(2) A policy that contains a cancellation provision may add [*the following clause*] at the end of the provision described in subsection (1) of this section **the following clause or an equivalent clause approved by the Department of Consumer and Business Services**: "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

(3) A policy in which the insurer reserves the right to refuse renewal shall have the following clause**, or an equivalent clause approved by the department,** at the beginning of the provision described in subsection (1) of this section: "Unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to the last address of the insured as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. The insurer shall state in the notice the reason for its refusal to renew this policy."

(4) Subsections (2) and (3) of this section may not be construed to permit the cancellation of or refusal to renew a policy if the cancellation or refusal to renew is otherwise prohibited by the Insurance Code or rules adopted by the department to carry out the provisions of the Insurance Code.

SECTION 6. ORS 743B.005 is amended to read:

743B.005. For purposes of ORS 743.004, 743.007, 743.022, **743.417,** 743.535, 743B.003 to 743B.127**,** [*and*] 743B.128**, 743B.250, 743B.323 and sections 2 and 3 of this 2021 Act**:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly

or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743B.010 to 743B.013; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(7) "Eligible employee" means an employee who is eligible for coverage under a group health benefit plan.

(8) "Employee" means any individual employed by an employer.

(9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

(10) "Exchange" means [*an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041*] **the health insurance exchange as defined in ORS 741.300**.

(11) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(12) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

(14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that is in effect on January 1, 2017.

(15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

(16)(a) "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies [*that are in effect for periods of three months or less, including the term of a renewal of the policy*];

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance

policy or equivalent self-insurance; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

[*(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.*]

(17) "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

(18) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(19) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(21) "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

(22) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(23) "Rating period" means the 12-month calendar period for which premium rates established

by a carrier are in effect, as determined by the carrier.

(24) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(25)(a) "Short term health insurance policy" means a policy of health insurance that is in effect for a period of three months or less, including the term of a renewal of the policy.

(b) As used in this subsection, "term of a renewal" includes the term of a new short term health insurance policy issued by an insurer to a policyholder no later than 60 days after the expiration of a short term health insurance policy issued by the insurer to the policyholder.

[*(25)*] **(26)** "Small employer" means an employer who employed an average of at least one but not more than 50 full-time equivalent employees on business days during the preceding calendar year and who employs at least one full-time equivalent employee on the first day of the plan year, determined in accordance with a methodology prescribed by the Department of Consumer and Business Services by rule.

SECTION 7. ORS 743B.250 is amended to read:

743B.250. All insurers offering a health benefit plan in this state shall:

(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

(a) The insurer's written policy on the rights of enrollees, including the right:

(A) To participate in decision making regarding the enrollee's health care.

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

(C) To have grievances handled in accordance with this section.

(D) To be provided with the information described in this section.

(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the Department **of Consumer and Business Services** by rule, and must include:

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

(C) The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances; and

(D) A description of the process for filing a complaint with the department.

(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by the department by rule.

(d) A summary of the insurer's policies on prescription drugs, including:

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

(D) Procedures by which a provider with prescribing authority may prescribe clinically appropriate drugs not included on the formulary;

(E) Procedures for the coverage of clinically appropriate prescription drugs not included on the

formulary; and

(F) A summary of the criteria for determining whether a drug is experimental or investigational.

(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks. The list must be available online and upon request in printed format.

(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

(g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

(h) Restrictions on services obtained outside of the insurer's network or service area.

(i) The availability of continuity of care as required by ORS 743B.225.

(j) Procedures for accessing after-hours care and emergency services as required by ORS 743A.012.

(k) Cost-sharing requirements and other charges to enrollees.

(L) Procedures, if any, for changing providers.

(m) Procedures, if any, by which enrollees may participate in the development of the insurer's corporate policies.

(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment.

(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information and the requirement under ORS 743B.555 that a carrier or third party administrator send communications containing protected health information only to the enrollee who is the subject of the protected health information.

(q) An explanation of assistance provided to non-English-speaking enrollees.

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743B.200, 743B.202 and 743B.423.

(2) Establish procedures, in accordance with requirements adopted by the department, for making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations.

(b) A method for recording all grievances, including the nature of the grievance and significant action taken.

(c) Written decisions.

(d) An expedited response to a request for an internal appeal that accommodates the clinical urgency of the situation.

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual health benefit plans and for any denial of an exception to a prescription drug formulary. If an insurer provides:

(A) Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

(B) No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

(f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have

exhausted internal appeals.

(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly comply with this section and federal requirements for internal appeals.

(g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing course of treatment under the health benefit plan pending the conclusion of the internal appeal process.

(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

(A) Submit for consideration by the insurer any written comments, documents, records and other materials relating to the adverse benefit determination; and

(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination.

(3) Establish procedures for notifying affected enrollees of:

(a) A change in or termination of any benefit; and

(b)(A) The termination of a primary care delivery office or site; and

(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

(4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

(5) Upon the request of an enrollee, applicant or prospective applicant, provide:

(a) The insurer's annual report on grievances and internal appeals submitted to the department under subsection (8) of this section.

(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

(c) Information about the insurer's procedures for credentialing network providers.

(6) Provide, upon the request of an enrollee, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease, to the extent the insurer maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743B.001 (7)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

(b) A general description of the reason for the grievance.

(c) The date the grievance was received by the insurer.

(d) The date of the internal appeal or the date of any internal appeal meeting held concerning the appeal.

(e) The result of the internal appeal at each level of appeal.

(f) The name of the covered person for whom the grievance was submitted.

(8) Provide an annual summary to the department of the insurer's aggregate data regarding grievances, internal appeals and requests for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, internal appeals and requests for external review.

(9) Allow the exercise of any rights described in this section **or ORS 743B.252 or 743B.255** by

an authorized representative.

(10) Procedures adopted under subsection (2) of this section for health benefit plans other than grandfathered health plans must be consistent with 42 U.S.C. 300-gg-19 and rules adopted by the United States Department of Health and Human Services implementing 42 U.S.C. 300-gg-19.

(11) An adverse benefit determination under subsection (2)(a) of this section that is provided to an enrollee in a health benefit plan other than a grandfathered health plan must:

(a) Be provided in a culturally and linguistic appropriate manner;

(b) Be consistent with federal requirements regarding the manner and content for notices of benefit determinations and federal requirements for the full and fair review of adverse benefit determinations; and

(c) Include the information required by subsection (4) of this section and:

(A) Information sufficient to identify the claim involved, the date of services, the health care provider and, if applicable, the claim amount;

(B) A statement describing the availability, upon request, of the information described in subsection (12) of this section;

(C) The specific reason for the adverse benefit determination, a reference to the specific plan provisions on which the determination is based, the denial code and the meaning of the denial code and a description of the standard that was used to make the determination, if any;

(D) A description of available internal appeals and external reviews, including expedited appeals and reviews, and instructions on how to initiate an appeal or review; and

(E) Contact information for the office of consumer assistance within the Department of Consumer and Business Services.

(12) Upon the request of an enrollee, an insurer that makes an adverse benefit determination with respect to the enrollee under a health benefit plan other than a grandfathered health plan must provide the enrollee with the diagnosis code, the meaning of the diagnosis code, the treatment code and the meaning of the treatment code that are associated with the adverse benefit determination.

(13) An adverse benefit determination issued to an enrollee following the final level of internal appeals by an insurer under a health benefit plan other than a grandfathered health plan must, in addition to the requirements under subsection (11) of this section, include:

(a) An explanation and discussion of the decision to uphold the initial adverse benefit determination; and

(b) An authorization form, or other document that complies with state and federal privacy laws and is approved by the department, with which an enrollee that requests an external review under ORS 743B.255 may authorize the insurer and the enrollee's treating health care provider to disclose medical records or other protected health information pertinent to the external review.

SECTION 8. ORS 743B.252 is amended to read:

743B.252. (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and ORS 743B.255 and rules adopted by the Director of the Department of Consumer and Business Services to carry out the provisions of this section and ORS 743B.250 and 743B.255. Each insurer shall provide the external review through an independent review organization that is under contract with the director to provide external review.

Each health benefit plan must allow an enrollee, by applying to the insurer or the director, to obtain review by an independent review organization of a dispute relating to an adverse benefit determination by the insurer on one or more of the following:

(a) Whether a course or plan of treatment is medically necessary.

(b) Whether a course or plan of treatment is experimental or investigational.

(c) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225.

(d) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

(e) Whether an exception to the health benefit plan's prescription drug formulary should be granted.

(2) An insurer shall incur all costs of its external review program. The insurer may not establish or charge a fee payable by enrollees for conducting external review.

(3)**(a)** When an enrollee applies for external review, the director shall appoint an independent review organization. When an independent review organization is appointed, the insurer shall forward all medical records and other relevant materials to the independent review organization no later than five business days after the appointment. The insurer shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. An independent review organization may reverse the adverse benefit determination if the insurer fails to furnish records, information and materials to the independent review organization in a timely manner.

(b) Paragraph (a) of this subsection does not require an insurer to disclose protected health information to an independent review organization if the disclosure is prohibited by state or federal law.

(4) An enrollee may submit additional information to the independent review organization no later than five business days after the enrollee's receipt of notification of the appointment of the independent review organization and the organization must consider the information in its review.

(5) The insurer and the director shall expedite the external review:

(a) If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the enrollee received emergency services, as defined in ORS 743A.012, and has not been discharged from a health care facility; or

(b) If a provider with an established clinical relationship to the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

SECTION 9. ORS 743B.254 is amended to read:

743B.254. An insurer [*of*] **offering** a health benefit plan shall include in the plan the following statements, in boldfaced type or otherwise emphasized:

(1) A statement of the right of [*enrollees*] **an enrollee** to apply for external review by an independent review organization;

(2) A statement that an enrollee applying for external review by an independent review organization may be required to authorize the release of any medical records necessary to conduct the external review; and

[*(2)*] **(3)** A statement that if the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer.

SECTION 10. ORS 743B.255 is amended to read:

743B.255. (1) An enrollee shall apply in writing for external review of an adverse benefit determination by the insurer of a health benefit plan not later than the 180th day after receipt of the insurer's final written decision following its grievance and internal appeal process under ORS 743B.250.

(2) An enrollee is eligible for external review only if the enrollee has [*satisfied the following requirements:*]

[*(a) The enrollee must have signed a waiver granting the independent review organization access to the medical records of the enrollee.*]

[*(b) The enrollee must have*] exhausted the plan's internal appeal procedures established pursuant to ORS 743B.250 or be deemed to have exhausted the plan's internal appeal procedures. The insurer may waive the requirement of compliance with the internal appeal procedures and have a dispute referred directly to external review upon the enrollee's consent. An enrollee is deemed to have exhausted the internal appeal procedures if the insurer fails to strictly comply with ORS 743B.250 and federal requirements for internal appeals.

[*(2)*] **(3)** An enrollee who applies for external review of an adverse benefit determination shall provide complete and accurate information to the independent review organization as provided in ORS 743B.252.

SECTION 11. ORS 743B.323 is amended to read:

743B.323. **(1)** Before a health insurer selling an individual policy or group health benefit plan[*, as defined in ORS 743B.005,*] may cancel a policy for nonpayment of premium, the insurer must mail a separate notice to the policyholder [*at least 10 days prior to the end of the grace period*] informing the policyholder that the premium was not received and that the policy will be terminated as of the premium due date if the premium is not received by the end of the applicable grace period required by ORS 743.417 and 743B.320.

(2) The notice **described in subsection (1) of this section** shall be in writing and mailed by first class mail to the last-known address of the policyholder[.] **at least:**

(a) Ten days prior to the end of the grace period specified in ORS 743.417 (1)(a) and 743B.320; or

(b) Fifteen days prior to the end of the grace period specified in ORS 743.417 (1)(b).

(3) The Department of Consumer and Business Services may prescribe by rule the information that must be contained in the notice required by subsection (1) of this section.

SECTION 12. ORS 743B.422 is amended to read:

743B.422. All utilization review performed pursuant to a medical services contract to which an insurer is not a party shall comply with the following:

(1) The criteria used in the review process and the method of development of the criteria shall be made available for review to a party to such medical services contract upon request.

(2) A physician licensed under ORS 677.100 to 677.228 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

(3) Any patient or provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(4) Except as provided in subsection (5) of this section, a determination on a provider's or an

enrollee's request for prior authorization of a nonemergency service must be issued within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

(5) If additional information from an enrollee or a provider is necessary to make a determination on a request for prior authorization, no later than two business days after receipt of the request, the enrollee and the provider shall be notified in writing of the specific additional information needed to make the determination. The determination must be issued by the later of:

(a) Two business days after receipt of a response to the request for additional information; or

(b) Fifteen days after the date of the request for additional information **unless otherwise provided by federal law**.